California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814-6237
Phone (916) 445-5014
Fax (916) 327-6308
www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

INSTRUCTIONS FOR FILING A NON-RESIDENT PHARMACY APPLICATION

Please follow these instructions completely. Failure to submit the necessary items will delay the processing of your application. Please allow approximately 90 days from the time your application packet is complete before calling the Board of Pharmacy.

Any forms or documents that have been previously submitted to the Board will not be pulled from the original file. You must complete and submit all of the requested information.

If you would like notification that the board has received your application, please submit a stamped postcard addressed to yourself.

Section A	Requirements for all applicants
Section B	Forms required for an applicant who is filing as an individual owner
Section C	Forms required for an applicant whose ownership is a partnership
Section D	Forms required for an applicant who is filing as a corporation 1. For profit 2. Non profit 3. Publicly traded corporation
Section E	Forms required for an applicant who is filing as a limited liability company
Section F	Requirements for change of location only (no ownership change)

CHECKLIST FOR FILING AN NON-RESIDENT PHARMACY APPLICATION

Section A All Applicants

[ ] 1. Application (17A-57) and non-refundable processing fee of $340.

[ ] 2. Ownership form

a. Corporation (17A-33)
OR
b. Partnership or Individual (17A-34)

[ ] 3. Financial Affidavit in Support of Application (17A-2)
(NOTE - *Not needed for a change of location or non-profit organization*

[ ] 4. Copy of lease agreement if the pharmacy premises is leased

If the premises is leased, rented or occupied by any person who is licensed in California to prescribe, a statement from the corporate attorney regarding prescriber control must be submitted.

[ ] 5. Seller's Certification for a Pharmacy (17A-8) (If applicable)
This is only required for an application for a change of ownership and it must be submitted by the prospective owner(s).

[ ] 6. Approved wholesale credit application or wholesale agreement
(NOTE - *Not needed for a non-profit organization*)

[ ] 7. A copy of the last inspection report.

[ ] 8. A statement indicating that you maintain records of controlled substances or dangerous devices dispensed to California patients, so that those records are readily retrievable from other drugs dispensed.

[ ] 9. Two prescription labels that include a toll free number.

[ ] 10. A list of pharmacists and their license numbers for those who fill prescriptions for California residents.

[ ] 11. An original letter from your state board verifying your state license is current and in good standing. The state seal must be embossed on the letter.

[ ] 12. Certification of Personnel (17A-11) and two completed fingerprint cards along with a $66.00 processing for the pharmacist-in-charge (see fingerprint instructions on page 7).

Section B Individual Owner who is not incorporated

In addition to items listed in Section A,

[ ] 1. The individual owner must submit:

- Certification of Personnel (17A-11)
- Individual Personal Affidavit (17A-27)
- Individual Financial Affidavit (17A-26)
- Two completed fingerprint cards along with a $66.00 processing (see fingerprint instructions on page 7

Section C Partnership

In addition to items listed in Section A, the following must be submitted:

[ ] 1. Each partner must submit:

- Certification of Personnel (17A-11)
- Individual Personal Affidavit (17A-27)
- Individual Financial Affidavit (17A-26)
- Two completed fingerprint cards along with a $66.00 processing (see fingerprint instructions on page 7

[ ] 2. Signed Partnership Agreement

If the partners are a corporation or a limited liability company (LLC), then complete and provide the same documents required of corporations (see section D).

Section D Corporations

The first line corporation over the pharmacy needs to complete a form 17A-33. Each remaining parent corporation, over the first line corporation, needs to complete a form 17A-33A.

For Profit

For the named corporation on the application and any corporation that is the parent of, or who owns an interest in, the corporation named on the application, the following is required:

[ ] 1. Each corporate officer, major shareholder, and director must submit:

- Certification of Personnel (17A-11)
- Individual Personal Affidavit (17A-27)
- Individual Financial Affidavit (form 17A-26)
- Two completed fingerprint cards along with a $66.00 processing (see fingerprint instructions on page 7

[ ] 2. Certification of Personnel (17A-11 for the pharmacist-in-charge)

[ ] 3. Articles of Incorporation **endorsed** by the Secretary of State.

[ ] 4. Statement

a. Statement by domestic stock **endorsed** by the Secretary of State. An endorsed copy must be requested from the Secretary of State.

OR

b. Statement by Foreign Corporation (form S/O 350) **endorsed** by the California Secretary of State. **This is only required if the corporation has any bank accounts in California; any corporate officers reside in California, or any pharmacies owned by the corporation are located in California.**

[ ] 5. By-laws

Non-Profit

For the named corporation on the application and any corporation that is the parent of, or who owns an interest in, the corporation named on the application, the following is required:

[ ] 1. Statement of nonprofit corporation, **endorsed** by the Secretary of State.

[ ] 2. By-laws

[ ] 3. Articles of Incorporation **endorsed** by the Secretary of State.

[ ] 4. Each corporate officer, shareholder, and director must submit:

- Certification of Personnel (17A-11)

[ ] 5. Certification of Personnel (17A-11) for the pharmacist-in-charge

Publicly Traded Corporation

[ ] 1. A copy of the corporation's 10K filing with the Securities Exchange Commission.

[ ] 2. A list of the five largest shareholders who own 5% or more of stock that requires a filing with the Securities Exchange Commission.

If the shareholder is an individual, include name, title and professional license (if applicable). Also, identify if the shareholder is a bank, trust company or financial institution to which a license is issued in a fiduciary capacity

Section E Limited Liability Companies

In addition to items listed in Section A, the following must be submitted:

[ ] 1. Each corporate officer, major shareholder, and director must submit:

- Certification of Personnel (17A-11)
- Individual Personal Affidavit (17A-27)
- Individual Financial Affidavit (form 17A-26)
- Two completed fingerprint cards along with a $66.00 processing (see fingerprint instructions on page 7

[ ] 2. Certification of Personnel (17A-11 for the pharmacist-in-charge)

[ ] 3. Articles of organization.

[ ] 4. Operating Agreement/Limited Liability Company Agreement.

Section G Change of Location ONLY (no ownership change)

[ ] 1. Application (17A-57) and the non-refundable processing fee of $60.

[ ] 2. Ownership

   a. Corporation (17A-33) **OR**
   b. Partnership or Individual (17A-34)

[ ] 3. Copy of the lease agreement.

[ ] 4. Each corporate officer, shareholder, and director must submit:

   a. Certification of Personnel (17A-11)
   b. Individual Personal Affidavit (17A-27)
   c. Completed fingerprint card and $66 fingerprint processing fee.**

[ ] 5. Pharmacist-in-charge must submit:

   a. Certification of Personnel (17A-11)
   b. Completed fingerprint card and $66 fingerprint processing fee.**

[ ] 6. Approved wholesale credit application or wholesale agreement
(NOTE - *Not needed non-profit organization*)

[ ] 7. A copy of the last inspection report.

[ ] 8. A statement indicating that you maintain records of controlled substances or dangerous devices dispensed to California patients, so that those records are readily retrievable from other drugs dispensed.

[ ] 9. Two prescription labels that include a toll free number.

[ ] 10. A list of pharmacists and their license numbers for those who fill prescriptions for California residents.

[ ] 11. An original letter from your state board verifying your state license is current and in good standing. The state seal must be embossed on the letter.

See ownership section for specific requirements, section B-D

** Effective January 1, 2001, the Board of Pharmacy requires all applicants for a new license to have not only a California Department of Justice (DOJ) criminal record check but also a federal background check. **No license will be issued without background clearances from both agencies.**

In order to complete the federal criminal record check, each owner, partner, corporate officer, major shareholder or director must submit rolled fingerprints on cards provided by the board and include a separate fee of $24. You may contact the board to request fingerprint cards at (916) 445-5014. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks. Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

Fingerprint Requirements

California Residents

The board will only accept Live Scan Service Forms from California residents.

Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning. Please refer to the Instructions for completing a "Request for Live Scan Service" form. Live Scan sites are located throughout California. For more information about locating a Live Scan site near you, visit the Department of Justice website at http://caag.state.ca.us/app/contact.pdf or the sources listed on the bottom of the instructions for completing a "Request for Live Scan Service" form.

The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

Non California Residents

If an owner, partner, corporate officer, major shareholder or director reside out of state they must submit rolled fingerprints on cards provided by the board and include a separate fee of $66 ($32 California Department of Justice (DOJ) fee, $10 DOJ expedite fee and $24 FBI fingerprint processing fee). (Live Scan processing fees are paid directly at the Live Scan site.) You may contact the board to request fingerprint cards at (916) 445-5014. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks (live scan is faster). Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

The board will only accept fingerprint cards from residents outside of California.

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NONRESIDENT PHARMACY PERMIT APPLICATION

Please print or type **ALL BLANKS MUST BE COMPLETED; IF NOT APPLICABLE, ENTER N/A**

Name of Pharmacy:	Pharmacy Telephone Number ( )
Address of Pharmacy: Street and Number City	State Zip Code

Indicate whether this application is for:

☐ New Pharmacy ☐ Change of Location of an existing pharmacy ☐ Change of Ownership of an existing pharmacy

If this is a **change of ownership** or **change of location**, indicate previous name, address and license number of pharmacy.

Date of proposed change of ownership or location:

Please indicate type of ownership:

☐ Individual ☐ Partnership ☐ Corporation ☐ Not-for-profit corporation ☐ Limited Liability

Name of agent for service of process in California	Agent's telephone number ( )
Agent's California address (P.O. box not acceptable) City	State Zip Code

Toll-Free Telephone Number for patient-pharmacist communication 1-888 1-800	Resident State pharmacy permit # & date issued

Do you mail replacement contact lenses to patients in California? Yes ☐ No ☐

By your affirmative answer above, your pharmacy name will be provided to the California Medical Board and you will be in compliance with section 4124 of the California Business and Professions Code.

CONTINUE ON REVERSE

FOR OFFICE USE ONLY

STAFF REVIEW		**CASHIER LOG**
☐ Articles of Incorp ☐ Partner agreement ☐ Seller's certificate ☐ Whlse agreement	☐ Financial Aff ☐ Stock Cert ☐ By-laws ☐ Lease	Approved _____ Denied _____ Date _____	Cashier # _____ Date _____ Amount of fee _____

Name of pharmacist-in-charge			Pharmacist license number
Residence address	City	State	Zip code
Indicate if you want all correspondence mailed to a different address. If correspondence should be mailed to the pharmacy, please insert "Same as Pharmacy."			
Name and telephone number of contact person to clarify information provided on this application. ( )			e-mail address:

PLEASE READ CAREFULLY

This application must be approved by the California State Board of Pharmacy before a pharmacy permit will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Any application not completed within 60 days of receipt may be deemed withdrawn by the Board of Pharmacy. Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.
The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the Executive Officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Section 1798.3 of the Civil Code.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an executive officer of the applicant corporation named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; (4) all supplemental statements are true and accurate; and (5) the transfer application may be withdrawn by either the applicant or the licensee with no resulting liability to the Board of Pharmacy.

_____	_____	_____
Signature of corporate officer, partner or owner	Name (please print)	Title
_____	_____	_____
Signature of corporate officer, partner or owner	Name (please print)	Title
_____	_____	_____
Signature of corporate officer, partner or owner	Name (please print)	Title

_____
Date

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PARTNERSHIP OR INDIVIDUAL OWNERSHIP INFORMATION

Please print or type **ALL BLANKS MUST BE COMPLETED; IF NOT APPLICABLE, ENTER N/A**

Name of premises:	Telephone number ( )
Address of premises: Number and Street City State Zip Code	

A. Partnership

If any of the partners listed below is a corporation or limited liability company, form 17A-33 must also be completed for each such entity. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist, veterinarian, etc., and the license number.

Federal Employer ID Number:* | | | | | | | | | |

Name or corporate name	Percentage owned %
Residence or corporate address	*Social security number
Licensed as / License number	States licensed in

Name or corporate name	Percentage owned %
Residence or corporate address	*Social security number
Licensed as / License number	States licensed in

Name or corporate name	Percentage owned %
Residence or corporate address	*Social security number
Licensed as / License number	States licensed in

B. Individual owner

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian; and the license number.

Name		Do you own 100% of business? Yes ☐ No ☐
Residence address		*Social security number
Licensed as	License number	States licensed in

PLEASE READ CAREFULLY. ALL PARTNERS/OWNERS MUST SIGN BELOW.

This application must be approved by the California State Board of Pharmacy before a pharmacy permit can be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in a response to any question is grounds for refusal or subsequent revocation of license, and is a violation of the Penal Code. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under the California Pharmacy Law. The officer responsible for information maintenance is the executive officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the applicant corporation named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; (4) all supplemental statements are true and accurate; and (5) the transfer application may be withdrawn by either the applicant or the licensee with no resulting liability to the Board of Pharmacy.

Signature of partner or individual owner	Name (please print)	Date
Signature of partner or individual owner	Name (please print)	Date
Signature of partner or individual owner	Name (please print)	Date

*Disclosure of your social security number (or federal employer identification number ["FEIN"], if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405[c][2][C]) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or your FEIN, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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CORPORATION OWNERSHIP INFORMATION

Please print or type **All blanks must be completed; if not applicable, enter N/A**

Name of parent corporation:	Telephone number ( )
Address of parent corporation: Number and Street City State Zip Code	
Name of applicant premises:	
Address of applicant premises: Number and Street City State Zip Code	

Is the applicant corporation a subsidiary? ☐ **Yes** ☐ **No**
If yes, name of parent corporation _____**. This parent corporation must complete a Parent Corporation or Limited Liability Company Ownership information form. Attach a diagram of the corporate structure showing the subsidiaries.**

A. Corporate Officers/Directors (Top 5 of each.)

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable). Non-profit organizations must list the names and titles of persons holding corporate positions.

Title	Name	Residence address & telephone number	Licensed as, license no. and state(s)

B. Owners/Shareholders

List all persons who own an interest in this corporation. If more than 5 shareholders, list the 5 largest (use additional sheets if necessary). List certificates chronologically, including active, cancelled, and pending issuance. If stock is pledged, include date, number of shares, and from whom to whom. Attach a copy of all stock certificates, transfer ledgers, and proof of purchase issued to date. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable).

To whom issued	Residence address & telephone number	Licensed as, license no. and state(s) licensed in	Cert #	% of Shares	Date Issued	Date cancelled

C. Ownership

If no stockholders exist, list all persons with a beneficial interest below.

Name	Residence address & telephone number

D. Does 10% or more of the ownership rest with any other entity? Yes No If yes, please list below

Name	Residence address & telephone number

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Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the executive officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814-6237. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him or her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

ALL OWNERS AND OFFICERS DESIGNATED ON THIS FORM MUST SIGN BELOW.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the corporation or limited liability company named on this application form, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license for which this application is made; and (4) all supplemental statements are true and accurate.

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

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PARENT CORPORATION OR LIMITED LIABILITY COMPANY OWNERSHIP INFORMATION

Please print or type **All blanks must be completed; if not applicable, enter N/A**

Name of parent corporation or limited liability company				Telephone number
				( )
Address	Number and Street	City	State	Zip Code
Name & address of premises	Number and Street	City	State	Zip Code

Is the parent corporation a subsidiary? Yes ☐ No ☐
If yes, name of parent corporation _____ . This parent corporation must also complete a Parent Corporation or Limited Liability Company Ownership information form. Please attach an organization chart.

A. Limited Liability Members or Manager(s) (Use additional sheets if necessary)

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable). Non-profit organizations must list the names and titles of persons holding corporate positions.

Title	Name	Residence address & telephone number	Licensed as, license no. and state(s)

For Limited Liability Companies Only: We, the undersigned members, authorize _____
(Name of member)
to sign all Board of Pharmacy forms, documents and operating conditions on our behalf.

B. Corporate Officers/Directors (Top 5 of each. Use additional sheets if necessary.)

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable). Non-profit organizations must list the names and titles of persons holding corporate positions.

Title	Name	Residence address & telephone number	Licensed as, license no. and state(s)

C. Owners/Shareholders

List all persons who own an interest (use additional sheets if necessary). List certificates chronologically, including active, cancelled, and pending issuance. If stock is pledged, include date, number of shares, and from whom to whom. Attach a copy of all stock certificates, transfer ledgers, and proof of purchase issued to date. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable).

To whom issued	Residence address & telephone number	Licensed as, license no. and state(s) licensed in	Cert #	% of Shares	Date Issued	Date cancelled

D. Ownership

If no stockholders exist, list all persons with a beneficial interest below.

Name	Residence address & telephone number

E. Does 10% or more of the ownership rest with any other entity? Yes ☐ No ☐

If yes, please list below

Name	Residence address & telephone number

This application must be approved by the California State Board of Pharmacy before a permit will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. Fees applied to this application are not transferable and are not refundable.

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the executive officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814-6237. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him or her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

ALL OWNERS AND OFFICERS DESIGNATED ON THIS FORM MUST SIGN BELOW.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the corporation or limited liability company named on this application form, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license for which this application is made; and (4) all supplemental statements are true and accurate.

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

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SELLER'S CERTIFICATION

INSTRUCTIONS: This form is to be completed by the seller and submitted by the prospective owner with the application for a change of ownership. Attach a copy of the pending purchase agreement.

NOTICE: The current permit is not transferable and the current owner of record must maintain operations and control of the licensed premises (including renewing the permit) until a new application is approved by the Board of Pharmacy. The new owner must complete and attach the new application to this document. (Proof of authority to sell by any person, except a person whose name appears on the original permit, must accompany this certification.)

(Please print or type) **All blanks must be completed; if not applicable enter N/A**

This will certify that _____
(name of individual, partnership* or corporation – "seller")

has agreed that on _____ "seller" shall transfer _____
month/day/year (all, half, etc.)

of the right, title and interest in _____ _____
(name of premises) (permit number)

located at _____
(street number and name) (city) (state) (zip code)

To _____
(name of buyer(s))

*IF A PARTNERSHIP, LIST THE NAMES OF ALL PARTNERS (all names must be listed)

On completion of this sale and approval of the new permit, the original permit, and the current renewal must be returned to the California State Board of Pharmacy for cancellation, before the new permit will be released.

Under penalty of perjury under the laws of the State of California, each person whose signature appears below certifies and says that: (1) he/she is the licensee, general partner or an executive officer of the corporate licensee named in this Seller's Certification, duly authorized to make this sale; and (2) all statements made in this Seller's Certification are true and correct. If the seller is a partnership, all partners must sign below.

Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date

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FINANCIAL AFFIDAVIT IN SUPPORT OF APPLICATION

All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information will be used to determine qualifications for registration under the California Pharmacy Law. The official responsible for information maintenance is the executive officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814-6237. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

Please print or type **All blanks must be completed; if not applicable, enter N/A**

Name of Corporation, Partnership or Individual Owner:	
Address of Corporation, Partnership or Individual Owner:	
Name of Pharmacy, Hospital, Wholesaler, etc:	
Premises Address: Number and Street City Zip Code	Telephone Number:

Indicate what part of the total investment will be in cash, and from what source(s) it will be or has been derived. **Please attach documentation.** $_____

Source: _____

_____

_____

List all other sources of funding for the pharmacy and how it will be paid. Provide the name, address, telephone number and amount. Use additional sheets if necessary. $ _____

Source: _____

_____

_____

If the pharmacy is franchised, list the name of franchisor:

Who will be the **primary** wholesaler for dangerous drugs and/or dangerous devices? Please attach a photocopy of the **approved** application filed with the wholesaler.				
Name of primary Wholesaler				Telephone number
Address of Wholesaler	Number & Street	City	State	Zip Code

Who will be the **secondary** wholesaler for dangerous drugs and/or dangerous devices? Please attach a photocopy of the **approved** application filed with the wholesaler.				
Name of secondary Wholesaler				Telephone number
Address of Wholesaler	Number & Street	City	State	Zip Code

Business Bank Name & Address (list all accounts for the pharmacy)	Telephone Number	Account Number	Balance of Account

Please submit a copy of most recent bank statement for each bank account listed above.

List all individuals authorized to sign on business bank account.

Signature	Name (please print)	Title

Name of bookkeeper/accountant for applicant premises:				Telephone Number ( )
Address of bookkeeper/accountant:	Number and Street	City	State	Zip Code

Estimated annual gross sales $_____	Estimated annual purchases $_____

APPLICANT(S) AUTHORIZATION FOR DISCLOSURE OF FINANCIAL RECORDS

For a period of nine months, from this date, for the purpose of authorizing the Board of Pharmacy to conduct an investigation on my/our qualifications pursuant to section 4207 of the Business and Professions Code, I/we hereby authorize the Board of Pharmacy, or any of its authorized personnel to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, notes and loan documents, deposit and withdrawal records, and escrow documents of my/our financial institution(s) or any financial records established in connection with this business.

I/we also authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business, including, but not limited to, those on file with my/our bookkeeper/accountant or with the escrow holder. I/we agree to furnish current financial information on the annual renewal if requested by the Board of Pharmacy. Applicant understands that falsification of the information on this form may constitute grounds for denial or revocation of the license.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing application, including all supplementary statements.

If corporation owned, one corporate officer must sign; if partnership owned, all partners must sign.

Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date

Date	Place	Attest (Notary Public)

California State Board of Pharmacy
400 R Street, Suite 4070, Sacramento, CA 95814-6237
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www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

INDIVIDUAL PERSONAL AFFIDAVIT

Please print or type **All blanks must be completed; if not applicable enter N/A**

Full name: Last	First	Middle		
Previous name(s) – include maiden name, also known as (AKA's), "aliases":				Attach a photograph taken within 60 days of the filing of this affidavit
Residence address: Number and Street	City	State	Zip Code	
Date of birth (month/day/year)	Place of birth (city, state, country)			
Driver's license no & state issued in	*Social Security number			**NO POLAROID**
Home telephone:	Current work telephone:			
Name of applicant premises: Number and Street	City	State	Zip Code	
Address of applicant premises:				
Premises telephone:				

I am (Check all that apply)

☐ Sole owner ☐ Officer ☐ General partner ☐ Financier/lender Other - Specify:
☐ Partner ☐ Director ☐ Stockholder _____% ☐ Member (LLC only) _____

Spouse's name (Include alias or maiden) Last	First	Middle
Spouse's social security number	Spouse's Date of Birth	Will your spouse work in any capacity under the permit? Yes ☐ No ☐

Do you have, or have you had, any direct or indirect beneficial interest in any other premises licensed by any board of pharmacy? Include sites licensed in states other than California.

Yes ☐ No ☐

If yes, list current direct or indirect beneficial interests (use an additional sheet if necessary).

Name	Address	Permit Number
Name	Address	Permit Number
Name	Address	Permit Number

If yes, list past direct or indirect beneficial interests during the last five years (use additional sheet if necessary):

Name	Address	Permit Number
Name	Address	Permit Number

Have you -- as an owner, shareholder, officer, member, director or partner -- been involved with a pharmacy, drug wholesaler, medical device retailer, hypodermic permit or out-of-state distributor whose license has been disciplined or an offer in compromise accepted or rejected by a state board of pharmacy or federal regulatory agency? Have you as an individual held a pharmacist license, pharmacy technician registration or exemption certificate that has been disciplined or an offer in compromise accepted or rejected by a state board of pharmacy or federal regulatory agency? Also describe if any of the above actions have occurred with your spouse or palimony partner, or an associate with whom you have shared any ownership interest. Describe the event, regulatory agency involved and date for each incident. (If yes, explain. Use additional sheets if necessary)

Yes ☐ No ☐

Have you as an individual ever been issued any professional or vocational license such as a medical doctor, attorney, dentist, contractor, etc. that has been disciplined by a state regulatory board? (If yes, explain.)

Yes ☐ No ☐

Current and past employment for at least the past five years. (Use additional sheets if necessary).

From (mo/yr)	To (mo/yr)	Type of Work	Firm name and city

Please read carefully and sign below.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, note and loan documents, deposit and withdrawal records, and escrow documents of my financial institution(s) or any financial records established in connection with this business. This authorization to examine records at any financial institution may be at any time. I also authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business including, but not limited to those on file with my bookkeeper.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing individual personal affidavit, including all supplementary statements and I personally completed this personal affidavit.

Applicant Signature Title Date

Place Attest (Notary Public

Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code, or for verification of examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

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CERTIFICATION OF PERSONNEL

INSTRUCTIONS: **Must be completed by each owner, director, officer, major shareholder and pharmacist-in-charge.** All blanks must be completed; if not applicable, enter N/A. Failure to furnish a complete explanation or any omissions **will delay** the processing of your application.

1. Full name (last, first, middle)	
2. Residence address (street, city, state, zip code)	Residence telephone number ( )

3. Are you currently licensed as a physician, podiatrist, dentist, optometrist or veterinarian in this state or any other state? If the answer is "yes," please list each license number, license type, and the state(s) where you are licensed. ☐ Yes ☐ No

License Type	License Number	State	Expiration Date

4. Is your spouse, child, parent, or other relative or any person with whom you share a financial interest, licensed in this state or any other state, as a physician, podiatrist, dentist, or veterinarian? If the answer is "yes," list the name of each person, their relationship to you, the license type, number and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name	Relationship	License Type	License Number	State

5. Are you currently, or have you previously been, listed as a corporate officer, partner, owner, manager, limited liability company member, administrator or medical director on a permit to sell, store or possess dangerous drugs or dangerous devices in this state or any other state? If "yes," please list the company name, permit type and number, position(s) held, state and expiration date. Please include information regarding cancelled permits. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of company	Type of permit	Permit number	Position held	State	Expiration date

6. Have you ever had a pharmacy permit, or any professional or vocational license or registration denied, suspended, revoked, placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state? If "yes," please provide permit type, action, company name (if applicable), year of action and state. (Use additional sheets if necessary.)

☐ Yes ☐ No

Name of person or business	Type of permit	Type of Action	Year of Action	State

7. Are you currently, or have you previously been, associated in business with any person, partnership, corporation, or other entity, or shared a financial or community property interest with any person whose pharmacy permit, or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken, by this or any other governmental authority in this state or any other state? If the answer is "yes," please list the company name, permit type, action, year of action and state. (Use additional sheets if necessary.)

☐ Yes ☐ No

Name of person or business	Type of permit	Type of Action	Year of Action	State

8. Have you ever been in violation of any provisions of pharmacy law, in this or any other state? If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)

☐ Yes ☐ No

Type of Violation	License Number	Type of Action	Year of Action	State

9. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States, any state or local jurisdiction? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside and/or dismissed under Penal Code section 1000 or 1203.4. (Traffic violations of $500 or less need not be reported.) If "yes," please attach an explanation which must include the type of violation, the date, circumstances and location, and the complete penalty received.

☐ Yes ☐ No

10. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health and safety risks?

☐ Yes ☐ No

If “yes,” attach a statement of explanation. If “no,” go directly to question 12.

11. Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program? ☐ Yes ☐ No
If "yes," please attach a statement of explanation.

(If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, or whether conditions should be imposed).

12. Do you currently engage in, or have been engaged in the past two years, in the illegal use of controlled substances? ☐ Yes ☐ No
If " yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to ensure that you are not engaging in the illegal use of controlled substances? **Please attach a statement of explanation.**

13. Will you work as an employee of this business? If yes, what will your responsibilities and duties be with this business? ☐ Yes ☐ No

_____

You must provide a written explanation for all affirmative answers to questions 3 - 12. Failure to do so may result in this application being deemed withdrawn as incomplete.

If you are a non-pharmacist owner, partner, corporate officer, corporate director or administrator of the business, you should be aware that:

(a) any non-pharmacist owner who commits any act which would subvert or tends to subvert the efforts of the pharmacist-in-charge to comply with the laws governing the operation of the pharmacy is guilty of a misdemeanor;

(b) you may not order a pharmacist to perform any act which is prohibited by law;

(c) any violation of the Federal Food, Drug & Cosmetic Act, the Federal Controlled Substance Act or any law or regulation relating to the practice of pharmacy in the State of California is grounds for suspension or revocation of the permit for which you are applying;

(d) committing any act prohibited by law, or neglecting to perform any duty required by law, could result in proceedings against the personal license of a pharmacist or could result in an action against your permit.

(e) you are not permitted to assist in any phase of compounding or dispensing of prescriptions, or to perform any of the duties which are required by law or regulation to be done by a pharmacist;

(f) only a pharmacist may possess the key to the pharmacy or to the permanent barrier separating the pharmacy;

(g) you may enter the pharmacy for the purpose of performing certain specified duties only when the pharmacist is present; and the pharmacist is responsible for any non-registered person allowed to enter the pharmacy. (This does not apply to hospital pharmacies or limited permits under Business and Professions Code section 4117, or Title 16, California Code of Regulations section 1714);

(h) dangerous drugs and/or devices as defined in Business and Professions Code sections 4022 and 4023 may only be sold on prescription or to persons who are licensed to handle, sell and possess such drugs.

All items of information requested on this form are mandatory. Failure to provide any of the requested information will result in the application being deemed withdrawn as incomplete. This information will be used to determine qualifications for licensure under California pharmacy law. The officer responsible for information maintenance is the executive officer, telephone (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814. This information may be transferred to another governmental agency, such as a law enforcement agency, if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Civil Code section 1798.3.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing certification of personnel form, including all supplementary statements ,and I personally completed this certification of personnel form.

I also certify that I have read and understand the rules of professional conduct and have retained a copy on file.

_____ _____

Signature Date

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STATE AND CONSUMER SERVICES AGENCY
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ARNOLD SCHWARZENEGGER, GOVERNOR

INDIVIDUAL FINANCIAL AFFIDAVIT

Please print or type **All blanks must be completed; if not applicable, enter N/A**

Full Name: Last	First	Middle	Telephone number
			( )

Residence Address	Number and Street	City	State	Zip Code

Premises Address	Number and Street	City	State	Zip Code	Telephone number
					( )

You must indicate one or more of the following:

- ☐ I am making a contribution: total amount $_____ cash amount $_____
- ☐ I am contributing labor/expertise only valued at: $_____
- ☐ I am receiving a loan: total amount $_____ (please attach copy of loan agreement)
- ☐ I am making a loan: total amount $_____ (please attach copy of loan agreement)
- ☐ I am not making a contribution in any form.

SOURCE OF FUNDS USED TO FINANCE BUSINESS

INSTRUCTIONS: Fully explain the source of your financial contributions (e.g. stock/bonds, real estate). If cash funds are from savings, indicate where the money was or is kept. If the source is from the sale of property, indicate what was sold, the address (if real estate), the name and address of the buyer, and the net proceeds from the sale. If a loan is involved, show the date, amount, terms, security, name and address of the lender. Describe any other sources of funds such as inheritances or gifts. Documentation may be requested.

SAVINGS **(Please use additional sheets if necessary)**

	ITEM 1	ITEM 2
Financial Institution(s)		
Address		
Amount		
Account Number		
Source of savings		

CHECKING **(Please use additional sheets if necessary)**

	ITEM 1	ITEM 2
Financial Institution(s)		
Address		
Amount		
Account Number		
Source of checking		

LOANS & CREDIT APPLICATIONS FOR THIS BUSINESS **(Please use additional sheets if necessary)**

	ITEM 1	ITEM 2
Date(s)		
Amount(s)		
Term(s)		
Item(s) secured		
Security(s)		
Lender(s)		

SALE OF PROPERTY TO FINANCE THIS BUSINESS (Please use additional sheets if necessary)

	ITEM 1	ITEM 2
Type		
Location(s)		
Date sold		
Buyer		
Net proceeds		
Other source(s)		

Will funding be provided in any amount from an individual, partnership or corporation whose professional or vocational license has been revoked, denied or in any other manner disciplined by a regulatory board in California or any other state?

Yes ☐ No ☐

If yes, please explain fully below (attach additional sheets if necessary). Attach copies of all disciplinary orders.

Please read and sign below in the presence of a Notary Public.

For a period of nine months from this date and pursuant to section 4207 of the Business and Professions Code, I hereby authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, note and loan documents, deposit and withdrawal records, and escrow documents of my financial institution(s) or any financial records established in connection with this business. This authorization to examine records at any financial institution may occur at any time. I also authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business including, but not limited to, those on file with my bookkeeper.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing Individual Financial Affidavit, including all supplementary statements and I personally completed this financial affidavit.

Applicant's signature

Title

Date

Place

Attest (Notary Public)